Senior Friendly Communities

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Senior Friendly Communities: Designing an approach for cross-border exchange of public health policy

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ABSTRACT

Communities are generally responsible for creating health policies for people with dementia, people with late-life depression and informal caregivers. So far, the exchange of knowledge and best practices on older people's public health between communities has remained limited, especially across borders. The cross-border Interreg Senior Friendly Communities (SFC) approach focuses on older people's public health in the Euregion Meuse-Rhine, a border region of Belgium, Germany and the Netherlands. It aims at supporting communities to promote healthy ageing, especially for people with dementia, people with late-life depression and informal caregivers. It makes use of the WHO's frameworks of Active and Healthy Ageing, with the pillars *health*, *participation* and *security*. The methodology of the SFC approach consists of a five-step approach: (1) creating an infrastructure for the SFC project (2); including communities (3); baseline assessments in the participating communities (4); creating an activity buffet of a variety of activities promoting older people's wellbeing; and (5) implementing the activities, conducting post-implementation assessments to measure the impact of SFC and creating a sustainability plan for communities to continue on this path. This paper discusses this five-step SFC approach that aims to address the limited use of cross-border exchange of health policies and best practices. It can serve as a guideline for other regions that deem the cross-border exchange of health policy valuable.

1. Introduction

The ageing of western populations in recent decades has brought new challenges to society. In Europe, it is estimated that the proportion of people aged 65 and older will have increased from 16,4% in 2010 to 25,6% by 2030 [1]. Coinciding with this increase, the prevalence of chronic diseases including mental illnesses, such as dementia and late-life depression, will also grow. The prevalence of important risk factors for depression – next to dementia a prevalent mental illness in late life – such as chronic conditions, disablement and loneliness, will also likely increase, resulting in higher numbers of older people with late-life depression. A related challenge to the increase of the prevalence of both dementia and late-life depression is the higher need for informal caregiving. People who provide informal care for others are at risk of developing health problems themselves, especially informal caregivers inside the household, although results may vary between countries [2].

These increases will in turn result in a higher burden on health(care) expenditures, a need for more informal as well as formal caregivers, and new ways to be found of helping people to age in place. To date, there is no cure for dementia. Progress has however been made in the prevention of dementia and the support of people with dementia and their informal caregivers [3,4]. The challenge to ageing societies for the coming years is therefore to aim for primary, secondary and tertiary prevention rather than waiting for a cure to the abovementioned diseases or expecting that informal

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care will become superfluous. This means for example developing policies in order to reduce the risk factors, and to reduce the emotional and financial impact of these conditions for individuals, families, communities and societies as a whole.

Governments are trying to prepare for and address such challenges with public health services, while in some countries the responsibility for providing healthcare and social care (such as public health services to older people) has been decentralised from the national to the regional or local level [5]. These local governments, in turn, expect that social networks will take at least some of the responsibility for providing care for people who need care [6–10]. Such a shift in responsibility for healthcare can be observed in several countries, such as the Netherlands and Belgium [5–7,9]. Furthermore, governments are increasingly trying to make public health care more effective and (cost-) efficient, for instance by promoting ageing in place and home care as much as possible [10].

Belgium, the Netherlands, and Germany have similar demographic profiles and therefore will face comparable challenges for the next decades. Although there are several initiatives tackling the challenges of living with dementia or late-life depression, or providing support to informal caregivers, the implementation and exchange across countries of good practices and knowledge remain limited. In order to enhance the exchange of knowledge, the Senior Friendly Communities (SFC) project was initiated as an innovative approach to address ageing in the Euregion Meuse-Rhine (EMR). Nine partners and 32 communities, distributed across the Belgian, German and Dutch parts of the EMR, participate in the project that develops and implements SFC, supported by the regional authorities. The project partners were organisations who were involved in public health in varying ways. Their networks were important for SFC to reach its stakeholders. In the participating countries, local communities were generally responsible for providing care and support to their vulnerable older people.

Similar to the concept of "dementia-friendly", but with a broader target group, SFC focused on helping the communities enabling a good quality of life and continued participation of their older people. "Friendliness" in this case meant that SFC 1) created awareness of the target groups at municipal policy level by means of an assessment and mystery guest (see Methods section) testing the extent to which municipalities were accessible, approachable and informed about activities; 2) gave feedback and advice how communities can facilitate the lives of older people across policy domains; and 3) offered various activities to be implemented that reduced stigma, promoted intergenerational contact, promoted self-reliance of older people and informal caregivers, and overall increased awareness. In particular, communities were encouraged to become more aware of their tasks for their older citizens, and to take older people's strengths and challenges into account in various policy domains, by exchanging several activities including training of local policy-makers in strategy development, local public health interventions, intersectoral action and cross-border collaboration, new roles for community personnel, people-centred approaches to care and well-being, and implementing information technology solutions. The three target groups of SFC were 1) older people (> 65 years) living in these communities with dementia and/or late-life depression (those who need care); 2) people who are currently a caregiver; and 3) older people who may become informal caregivers in the near future.

The project was based on the healthy and active ageing frameworks of the WHO, which are discussed in the Methodology section. Additionally, SFC did so while pragmatically making use of the possibility of exchanging existing knowledge and best practices across the border region. So far, such a systematic exchange hardly took place. We believe this innovative approach could serve as a model for others striving to reach comparable goals, even for other topics than dementia, late-life depression and informal care.

This paper describes the aims and design of the SFC project as an example for other regions where similar challenges are encountered as described above. Before we will elaborate on this, we will briefly describe the EMR and the characteristics of the participating communities.

1.1. The Euregion Meuse-Rhine and the participating SFC communities

The EMR consists of five regions with three language areas, i.e., Belgium Limburg (Netherlands), Province of Liege, Wallonie (French speaking), the German speaking communities in Belgium, the Dutch Province of Limburg, and the German region Regierungsbezirk Köln. The total population includes approximately 4,4 million people [11]. The proportion of people older than 65 years in the EMR is on average 9,8% (range 8,7 %–10,6%) [11]. The population size varies largely among the 32 participating SFC communities, ranging from 4000 to almost 200,000 inhabitants. Most communities are located in a rural area, with only three larger city areas with more than 100,000 people (i.e., Venlo, 101,000 inhabitants; Maastricht, 121.000 inhabitants; and city of Liege with 197,000 inhabitants). The population is largely Caucasian, and general income is not particularly poor or rich. A notable characteristic is that the border zone between regions is relatively large. For more details on the regions, the reader is referred to the Euregional Health Atlas (http://euregionalhealthatlas.eu) which is one of the products of the SFC project, and which combines statistical data on demographics, care, health, lifestyle and quality of care in the EMR [12].

2. Methods

2.1. WHO policy framework: active and healthy ageing

SFC is based on the policy framework of Active Ageing (2002) of the World Health Organization (WHO). The three pillars of the Active Ageing framework, namely health, participation and security, constitute the conceptual basis of the SFC approach. The WHO defines Active Ageing as "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" [13]. This is what SFC aims to help communities to do when becoming more Senior Friendly Communities. The three pillars represent the ways to achieve this goal.

The health pillar asserts that keeping risk factors for chronic diseases and functional decline low and protective factors high may result in more quantity and quality of life, more self-reliance and less medical costs for older people. At the same time, "those who do need care (. . .) should have access to the entire range of health and social services that address the needs and rights of women and men as they age" [13]. Participation refers to the full participation of older people in socioeconomic, cultural and spiritual activities, and continuing to contribute to society according to their own capacities, preferences and needs. Lastly, the third pillar attends to the social, financial and physical security. It recommends that policies and programmes should address these security needs of ageing people and support families and communities in "efforts to care for their older members" [13]. After SFC was designed and prepared, the current WHO framework changed from Active Ageing to Healthy Ageing, in which the pillars of active ageing still fit.

2.2. The five steps of SFC

The general idea of the SFC approach was that it should be practical and applicable in other regions as well, as the project stimulates the use of capacities, knowledge and best practices that were already existing somewhere else in the region, and making these

available to all participating communities. Examples of best practices were for instance training of well-being coaches who closely work together with primary care physicians; outreach activities offered by trained volunteers to socially isolated older people; educational sessions on ageing, positive health, communicating with people with dementia and on empowering informal caregivers; education in primary schools on dementia and depression; and online support tools for informal caregivers. The SFC approach is less time-consuming than inventing new interventions and ensures that interventions whose practical applicability has already been demonstrated are used. Some of the interventions included in the project, such as the e-health interventions (see below), have been based on theoretical frameworks such as the MRC's Framework for design and evaluation of complex interventions to improve health [14].

The approach of SFC consisted of five steps, of which four take place in the preparation phase (see Fig. 1). The four steps in the preparation phase included: [1] creating the infrastructure of the SFC project [2], selecting and including the communities [3], developing the assessment methodology and 'mystery guest' methodology, and [4] developing the activity buffet. The fifth step consisted not only of implementation but also ensured the durability of the impact of SFC by creating a sustainability plan for the participating communities in order to stay engaged with the target groups after the project has ended. Fig. 1 visualises these five steps:

2.2.1. Step 1: creating an infrastructure

The first step of the SFC approach was to create an administrative infrastructure, which is illustrated in Fig. 2. Within the SFC in the EMR project, a management board and a project group were initiated, both in which (different) representatives of the project partners had a role. The management board's main responsibility is overseeing the project at large, taking financial responsibility and organisational decisions, which were executed by the project group. Some project group members were appointed as regional coordinators who acted as the linking pins to the communities in their regions, and who monitored the implementation process. In principle, both teams met monthly. The partners were represented in both the Management Board as the Project Group, albeit often by different members of the partner organisation as the Management Board comprised of more senior staff or members from the financial departments. In terms of the different roles of project partners, Maastricht University provided the research part, euPrevent brought in their experience with cross-border collaboration in the field of public health, and the other project partners are organisations that deal with public health in their regions in varying ways, for example regional health services or patient/citizen advocacy, all of them having had experience with older people in particular. The regional coordinators were from different project partners in each region and provided the linking pin to the communities.

2.2.2. Step 2: selecting and including communities

The funding of the SFC project allowed us to include a maximum of 30 communities, i.e., ten per country but in the end 32 out of in total 173 communities were included, as two Dutch communities additionally financed their participation themselves. Participating communities were dispersed over the five regions of Interreg EMR, which includes the German-speaking communities (n = 2 communities), the Province of Liège (n = 4), and the Province of Limburg (n = 4) in Belgium; Regierungsbezirk Köln in Germany (n = 10); and the Province of Limburg in the Netherlands (n = 12). All communities in the abovementioned area were invited via an open call on the basis of first come, first served. This resulted in a diverse mix of communities in terms of size, location and previous engagement with the topics of dementia, late-life depression and senior friendliness in general. Each participating community was asked to attend information meetings, sign a partner agreement and designate one key contact person for the SFC project group, who would be in regular contact with his/her respective local coordinator from the project group. This step was not only meant to include as many communities as the funding could provide for, but also to create a partnership and ensure commitment by the participants for the duration of the project.

2.2.3. Step 3: the baseline assessment: interviews and 'mystery guests'

As a third step in the preparation phase, baseline assessments were developed to investigate current policies and needs of communities regarding the support of the SFC target groups. During this step, the regional coordinators exchanged information on the differences and similarities between the regions' health systems, to anticipate whether the assessment questions would be suitable for all regions and what kind of influence the differences in health systems could have on the selection of activities (step 4). First, questionnaires for use during the semi-structured interviews regarding the community policies were created. The comprehensive list of questions can be found in the Appendix. The mix of close-ended and open questions were partly derived from existing questionnaires that had been tested previously in the Netherlands [15,16]. Further, questions on the topics of health, participation, and security were added. Open questions were included asking about what the community had to offer for older people. The questionnaires were divided into three sections. The first section comprised questions about (a) capacities of the community, including capacities to collaborate with other organisations in its own region in general;(b) the collaboration in the Euregion in general, and (c) the collaboration more specifically on the topic of mental health. Further, a set of questions in this section investigated the general capacities of the communities, such as the identification of stakeholders, the maintenance of networks, gathering of data and acting upon the needs expressed by their citizens.

The second section of the baseline assessment consisted of a needs assessment, examining the status quo of the communities in terms of how they were dealing with the topics of dementia, late-life depression, and informal care. The questions here were divided into three categories. Questions from the first category examined the topic of mental health in general, including questions about the community's support for informal caregivers. Questions from the second category addressed how the community supports people with depressive symptoms. The questions from the third category examined how the community supports people with dementia. Thereafter, there was a question for each of the three WHO pillars to determine how the communities gave substance to the topics of participation, health and security, respectively. Lastly, this second section investigated what tangible actions the communities had already taken or planned to take in the near future to improve the accessibility of healthcare and support for older people. The third and final section of the baseline assessment investigated the extent to which the activities that the project group had in mind (see step 4) would fit the needs of the communities.

In addition to the baseline assessment interviews, SFC adopted a mystery guest method that was designed by one of the project partners after the example of the Dutch Health Inspectorate and international literature [17,18]. The reason for adopting this method was that the above-mentioned baseline assessments would largely provide for a self-assessment of the communities and mystery guests would complement the information gained from those assessments. Mystery guests are volunteers who are trained to act as a concerned citizen or family member of an older person with mental health problems, asking the community for support. The goal was to test how easily available such support and information regarding senior friendly policies is in the communities.

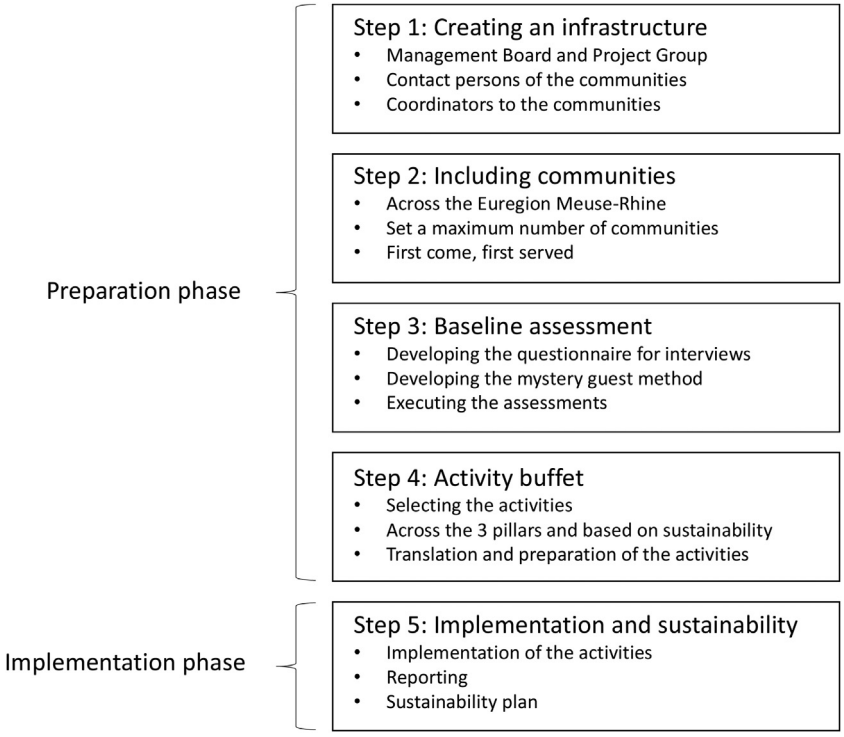

Fig. 1. Five-step plan of the SFC approach.

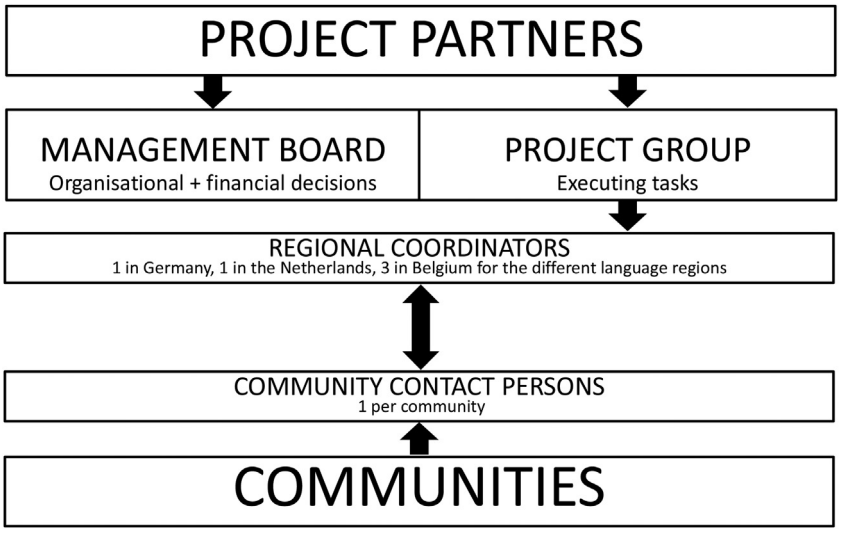

Fig. 2. Organisational chart of SFC.

Project partners designed the role descriptions and instructions that the mystery guests used as background stories (one on dementia and informal caregiving and one on late-life depression and informal caregiving) when they visited and/or examined the communities. The project partners further asked for input from a panel of "experts by experience": informal caregivers and professionals who had dealt with people living with dementia and/or late-life depression to inform the background stories. The structure of the assessment with the interview questionnaires and mystery guests, resulting in individual community reports, is illustrated in Fig. 3.

The baseline assessment took place at the municipal offices of the participating communities. The invitation to the semi-structured interviews was sent to the community's contact person, who was responsible for deciding whether (or not) to invite other interviewees deemed knowledgeable about SFC's topics and the current policy and needs of the community. This open invitation could result in a wider range of interviewees, from various backgrounds, e.g. policymakers, directors of old people's care homes, or members of advisory bodies on ageing/social policy or dementia organisations. The mystery guests visited and/or contacted the communities anonymously and at arbitrary times within the assessment interview period. The mystery guest method will be elaborated on in a separate paper. The project group processed the insights gained during the interviews and the experiences from the mystery guests and combined the results into individual community reports with advice as to what parts each respective community could improve. The communities received these reports before the implementation phase (step 5) started. The Eure-

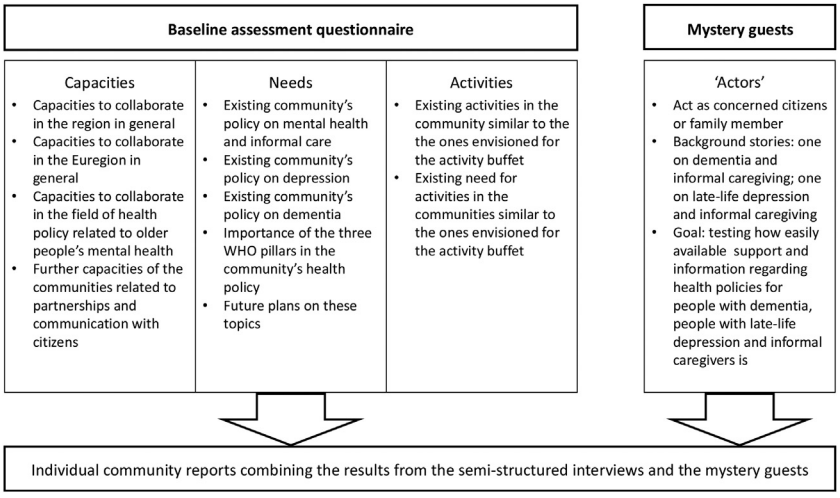

Fig. 3. The SFC baseline assessment structure.

gional results from the baseline assessments will be published elsewhere, as the present paper focuses on the preparation and implementation of the SFC approach.

2.2.4. Step 4: the activity buffet

Simultaneously to the third step, the SFC project team made preparations for the activity buffet. This was a selection of fifteen already existing interventions or activities that support people with dementia or late-life depression or informal caregivers. It was metaphorically named a "buffet" since communities were allowed to choose several activities from it in the implementation phase of the project, within the constraints of virtual financial budget set by the project group. Activities had to aim to support at least one of the three target groups, and had to be selected along the three WHO pillars, ensuring a diverse offer of activities. This variation resulted in a balanced offering from which communities with different needs could choose (see Fig. 3). Another criterion was that the activities had to be previously developed in (one of) the EMR regions, and to some extent already been tested prior to the SFC implementation, i.e., that had already been proven to be helpful and to ensure the cross-border exchange of best practices and knowledge. The project group hired translators to translate all activities into the respective languages (Dutch, German, French) and adapted them to the specific socio-cultural contexts of the participating regions. As a result, the communities could readily implement, with support from their respective coordinators, any of the activities of their choice without further intervention by translators. Thereby, SFC facilitates the cross-border exchange of knowledge and best practices. Lastly, in order to ensure sustainability, the project group selected activities that could be continued at the municipalities' expenses after the official end date of the preparation and implementation phases of the SFC in the EMR project (December 2019). Fig. 4 provides an overview of the activities with a description of the activity, the country in which they were developed, for which target group they are suitable, and which WHO pillar they address. More information can be found in the digital version of the SFC EMR Activity Buffet Brochure (https://www.euprevent.eu/wp-content/uploads/2018/02/WEB-Brochure-Activiteitencongres-EN.pdf). Some of the activities also have their own websites, such as Confetti in the Head (Konfetti im Kopf: https://konfetti-im-kopf.de/), Crossing Borders in Health (https://euprevent.eu/products/activities/), Education in Schools (Adoptieproject: https://www.alzheimercentrumlimburg.nl/adoptieproject), InLife [19,20] (https://www.myinlife.nl/en), Partner in Balance [21] (Partner in Balans: https://www.partnerinbalans.nl/home/en/), Positive Health [22,23], the Theatre (https://setheater.nl/Acts/vergetenverzonken/), and Wellbeing on Prescription (Welzijn op Recept: https://welzijnoprecept.nl/).

2.2.5. Step 5: implementation and sustainability

During the implementation phase, which takes place in 2018 and 2019, the communities of the SFC in the EMR project first implement the activities of their choice. The communities are subject to rules when choosing the activities, among which there is a rule that they have to choose at least one activity from a different region or country than their own. Thus, during the selection process of the activities, SFC strongly promotes its cross-border aspect in the communities' selection of activities. The communities can use the reports that resulted from the baseline assessments and may consult their respective coordinators regarding their choices for activities to be implemented. Apart from the abovementioned rules, however, the communities are free to base their choices on the report and the advices included or not. Furthermore, communities are free to choose whether they want to implement several at a time or spread activities over a longer period of time, as long as these are all implemented before the end date of the implementation phase: the end of 2019 for SFC in the EMR. Although the activities are translated and adapted to local circumstances and mostly ready to be implemented, the communities themselves sometimes have to arrange some local requirements, such as adequate settings for activities to be held, and they are responsible for promoting the activities.

The final part of the implementation phase supports communities to continue on the path of working on their senior-friendliness. The SFC project group investigates to what extent the communities' policies and their support for the target groups have changed since the beginning of SFC. It does so by conducting post-implementation-assessments with semi-structured interviews similar to the baseline assessments. Results from the baseline assessment and post-assessment are compared for the respective communities to see whether their capacities and needs have changed during the project time period. In the end, each community will receive a report describing the results of their post-implementation-assessment. In addition, the reports will comprise an individual sustainability plan for each respective community to continue to work on SFC topics even after the official end date of the SFC project.

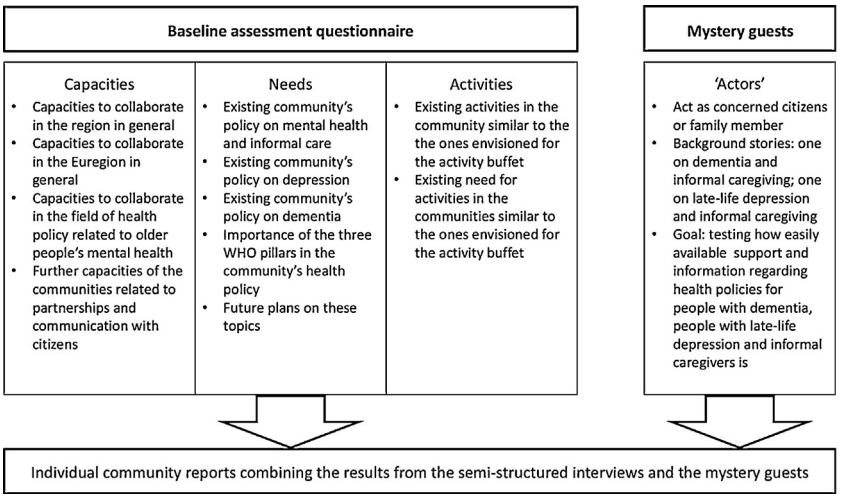

Fig. 4. The division across target groups and pillars of the activities included in the SFC activity buffet [24].
*The pillars are derived from the WHO (see Method section).

3. Discussion

In this paper, we have described the five steps in the preparation and design of the SFC approach as an example for other regions to set up a cross-border collaboration on public health. SFC has recently been formally identified as a good practice promoting healthy ageing for people with dementia and late-life depression by the WHO in one of its Good Practice Briefs, the aim of which is "strengthening the health system response to noncommunicable diseases" [25].

The SFC approach may allow for several benefits. First, it helps communities to transcend regional and national borders to learn from each other, so they can work more efficiently. Although the assessments are still being analysed, one preliminary result was the often heard response that it was helpful to become more aware of the issues at stake and to be inspired by such diversity of activities that they perceived as helpful. Second, SFC offered the participating communities activities that have been developed and pre-tested in the region, and therefore have already shown to effectively support the target groups. Third, SFC provides translations of these activities into the language and political context of the different regions, which makes them directly applicable in each community's country-specific context. In that regard, country-specific context is an important aspect of public health capacity and despite the similar demographic profiles, the project's regions are different in terms of political context, which should be taken into account [10,26]. By providing translated and adapted activities, the project facilitates the implementation procedure for communities, saving them time and money, and lowering the barriers to participation. Fourth, SFC stimulates the sustainability of the activities and creates a sustainability plan for the communities so that they can continue to work on becoming more senior friendly after the SFC project has ended. Finally, the project's plenary meetings involve all the communities, which can result in strengthening the regional network and creates opportunities for the communities to collaborate even on other topics.

The effect of the approach of SFC on citizens may include increasing their awareness and familiarity with the topics of dementia, late-life depression and informal caregiving. As a result, people with dementia or late-life depression and informal caregivers may feel more understood and feel less hesitant to share their situation and experiences with others or ask for help. This in turn may increase their wellbeing and ability to live their lives within the community and age in place within a senior friendly community. The Euregional aspect of the project may be less known except if the communities advertise this. Nevertheless, citizens who are aware of this aspect of SFC may also be more inclined to seek support across the border. Results and feedback from the communities on the five steps are still being analysed and will be reported in a future article. However, preliminary results show that the steps would not be adapted to a large extent.

The SFC approach seems to be well suited to tackle the challenge of ageing by making use of the knowledge and activities that already exist in the region and to facilitate the exchange thereof. Rather than reinventing the wheel, it takes a pragmatic approach and uses the means available to create senior friendly communities that are well equipped to support people with dementia, people with late-life depression and people who provide informal care. As a result, this facilitates people to continue to live in their communities and participate in daily and social life as much as possible on their own terms. Many policymakers in communities appeared not to be not fully aware of how their communities can support people with dementia or people with late-life depression. Adopting the SFC model could be helpful as it offers a blueprint for a community to become more aware and supportive towards older people with mental health problems and learn from how other communities are fulfilling those tasks.

One of the challenges of the preparation and implementation of the SFC approach in the EMR may be its limited time period: three years. This may prove to be too short as real changes in the attitude and policy of a community may only become visible over a longer period of time. For this reason, the current SFC approach was planned for three years and chose to implement existing activities as creating new activities would take longer than the proposed timeframe. Despite this challenge, however, SFC deemed it valuable not to reinvent the wheel but make use of existing, proven effective activities. A further advantage of the cross-border exchange, even if it can be financially and time-costly, is that communities have expressed that they find it inspiring. Some communities already collaborate across the border on topics like the tourism, transport and the labour market, and this project demonstrates to communities that there are more topics that they can collaborate on. Gaining a fresh perspective on policies and activities can be of added value as well, as Dutch communities reported they found it helpful that the originally Dutch activity Wellbeing on Prescription was further adapted for SFC in Belgium and was thereafter also implemented in Dutch communities, giving them new insights. The added value is thus to inspire communities to think outside the box and look

beyond their usual partners, but it is important to set a realistic plan and budget. Furthermore, one of the goals of SFC is to support the cross-border exchange of existing policies, good practices and existing activities, rather than reinventing the wheel. As a result of contextual differences, such as different culture, policies, financial structures etc., best practices may have somewhat different outcomes in different regions. Furthermore, despite the benefits of exchanging knowledge and best practices across borders, translations and adaptations cost time and money. A project that would focus entirely on one region and that would not need such translations and adaptations could be potentially implemented more quickly.

A further challenge in involving communities refers to managing their expectations. Despite the benefits of implementing pre-existing activities, some communities expressed their preference for an approach in which SFC would create new activities after the assessments. This would however not be feasible within the goals and timeframe of SFC. A further challenge in managing expectations was deciding the extent to which the project group's regional coordinators should steer the community. Whereas SFC has mainly facilitated the exchange of knowledge and best practices, as well as increasing the awareness for people with dementia and late-life depression in relation to policy in general, some communities expressed a need for more guidance in choosing activities and a desire for pre-formulated policies.

Another challenge is to involve communities. First, it may be difficult to keep communities involved when the focus turns to the short term due to elections and political party shifts, at the expense of long-term projects. This may make it difficult to keep professionals on the political level who are mainly involved with the SFC's target groups involved. However, other stakeholders such as representatives of care homes, of care organisations, or of senior's advisory councils may have a large influence on the senior friendliness of a community as well. In regions other than the EMR, the responsibility for supporting older people and informal caregivers may lie at different political levels, which should be kept in mind when implementing SFC elsewhere. Additionally, the term "community" can be regarded as a broader concept than municipality, as the former also involves stakeholders other than policymakers and politicians. SFC has tried to incorporate all stakeholders by asking the policymakers to invite relevant stakeholders to the assessment meetings, but as a result some stakeholders may have been missed. Finally, one should not underestimate the time it takes to build up a large network and trust among participating communities and other partners, such as is needed for SFC. Therefore, it is important to include project partners with an existing network and if possible (Eu)regional experience. Some factors for SFC to work successfully could be identified: from the beginning it is important to establish the tasks of the municipalities in supporting older people with mental health problems and informal caregivers, as this varied across countries of the EMR. They should prioritise these topics, meaning that they be willing to allocate adequate time, budget, and dedicated staff to take on this role, and must be well aware of these roles at political- and policy- level. And finally, they have to know the relevant stakeholders who they should bring together.

Within SFC in the EMR, the specific topics of dementia and late-life depression were higher prioritised. However, the approach described in this paper can not only be applied to and benefit other regions but can also be applied to other public health topics. This is especially true for organisations that wish to address public health topics from a cross-border perspective. The most important condition for implementing such a project is knowing who has a responsibility in offering support and care for people with dementia, people with late-life depression and informal caregivers. Depending on the country and political and healthcare system, this may be a different entity than the municipalities. SFC is applicable to different parts of the world to different communities and with various kinds of project partners, provided one brings together the partners who are most suitable and responsible for the target groups. Local-level multidisciplinary intersectoral action is needed to support healthy ageing, particularly for those with dementia and late life depression. All five regions are located quite peripherally in their respective countries, which can be a challenge to interact. While we are still analysing the reassessment, we expect that the emphasis on cross border exchange will enhance collaboration among local policy makers who share the same responsibilities for these aged citizens, and will complement what is available already on the national level. This article, describing the methods of SFC, can serve as a blueprint of what actions regions can undertake to implement a similar project, benefiting from cross-border exchange in the field of public health. Data on the results of the project will be published in a future article.

4. Conclusions

The Senior Friendly Communities approach tackles the challenges that arise with the ageing of society by using a cross-border approach. It supports communities that want to become more senior friendly, in particular communities that want to support people with dementia, people with late-life depression, and informal caregivers. By facilitating the exchange of knowledge and best practices across borders in the Euregion Meuse-Rhine, the project prevents that communities have to reinvent the wheel. This paper provided an overview of how the SFC in the EMR project has done so and could lead as a blueprint to others who want to adopt this SFC approach in a different region or on different topics, also from a cross-border perspective.

Declaration of Competing Interest

The authors declare that they have no conflict of interest.

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